

## The delivery of health care alternatives: discussion paper

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### Introduction

A recent Government white paper in England (Working for Patients, January 1989) suggested a radical restructuring of health care with emphasis on a consumer-based service. This reflects a growing movement throughout Europe whereby health care initiatives are responding to consumer demand. Some of these initiatives may be based on what is currently regarded as 'complementary' medicine.

The term complementary medicine is used in this paper to refer to what is often called 'alternative' or 'un-orthodox medicine'. 'Complementary medicine' indicates approaches which are independent from modern scientific medicine, but have a potential for working with such medicine in a broader context of health care delivery.

Despite the apparent growing popularity of complementary medicine, there are few population based data<sup>1</sup>. In a study of complementary medicine in nine European countries Sermeus<sup>2</sup> found that between 6% and 24% of the national populations had consulted a practitioner of alternative medicine, whether a qualified medical practitioner or not, during the previous 12 months. The most common form of complementary medicine was homeopathy, followed by acupuncture and then the manipulative therapies. Hill<sup>3</sup> reports that 9% of consultations in the United Kingdom, excluding those made in hospitals, are with practitioners of complementary medicine. Yung<sup>1</sup> found that 2.6% of his random sample of patients in Cardiff, Wales reported some form of complementary medical treatment *not* on the National Health Service in the previous year, and suggested that demand may be suppressed by an inability to pay.

This emphasis on consumer choice and demand reflects what happens anyway. People choose how they wish to maintain and promote their own health. A possible reason for the popularity of complementary medicine is that the involvement of the patient in his or her own health care is recognized by the practitioner. Other reasons given for choosing complementary therapies are; that they may include a psychosocial approach<sup>4</sup> to problems, that the patient's search for health is understood in terms of reasons and intentions<sup>5</sup>, and that there is an acknowledgment of the intent of both parties to cooperate in health care. There is less a turning away from orthodox medical care because of dissatisfaction, more a demand for mixed pluralistic health care.

In the patient's search for treatment formal health care delivery often comes late in the chain of decision making. It is only we health professionals who emphasize the formal health care network, ie a 'top down' approach. Health care requirements in a consumer based approach are

determined from the needs of the users, ie a 'bottom up' approach<sup>6,7</sup>.

It may also be prudent for health care decision makers to consider how health care can be delivered in a pluralist European health care culture, ie one which acknowledges modern scientific, traditional and complementary medicine. There are lessons to be learned from our neighbours across the channel. Other European countries have attempted to integrate alternative medical approaches<sup>2</sup> and we can learn from each other what are the optimal conditions for a mixed health care system.

If we are to implement a consumer based health plan which emphasizes choice, and which includes 'complementary' medicine, then it will be necessary to promote an atmosphere of permissive legislation for the control and licensing of a broad spectrum of practitioners, and develop economic financing and delivery arrangements<sup>7-9</sup>. The structure of such arrangements will depend upon knowledge of the process of health care delivery and organization<sup>10</sup>.

Information about competing treatments may also bring about an improvement in health care and reduce the escalation of health costs<sup>8</sup>. There are a number of serious difficulties for workers in this field. As yet there is no coordinated research strategy at a European level for collecting health care data. The definition of terms; 'health', 'health promotion', 'quality of life', and 'health care outcomes' (to name but a few) need to be agreed so that we can collect some population based data.

### Health care information

Before we can develop new ways of delivering health care we will need to rectify the serious lack of information concerning the costs, benefits and output of health care initiatives. While the British Government is attempting to introduce information technology into the National Health Service, there is no attempt to ascertain the costs of such organizational change. The implementation of procedures based on political ideology, before rigorously assessing the impact of those procedures, perpetuates the perennial problem of ad hoc health planning without understanding the need for the resources of time and trained personnel.

To attempt to implement information technology without a knowledge of the health care system is to implement non-information technology. Furthermore, to implement any information strategy without careful consideration of users' needs is folly. Such technology is not used. Strategies for the collection and dissemination of information have to be developed collaboratively with users, with commonly defined objectives and commonly understood criteria as to

what counts as information. Not only do patients want to know more about their illnesses, they want to now more about the various treatments which are available.

If an aim of the new health care initiatives is to improve service then we can learn from industry<sup>11</sup>. Quality is improved by attending to the process of delivery where suppliers are in a close dialogue with consumers. This also reduces costs. Any new attempts to collect information must begin at this primary care interface between the medical practitioner and the patient, and the medical practitioner and his or her sources for referral. This would mean an emphasis on local networks according to local need.

However, we must first understand the complex process of health production before we can try to improve it, particularly in the field of chronic illness as it presents itself in primary health care. An understanding of health production must also be supplemented with measurement tools which represent the values of the producers at the workplace (practitioners), and the consumers with whom they meet (patients). Epidemiological methods must be developed to establish baselines from which the success of health care initiatives can be measured and outcomes can be monitored<sup>12</sup>. It is imperative then that a common language for health outcomes is developed. This must be understood by the consumers (patients), deliverers (practitioners) and providers (those who pay).

When we speak of health care we are not only concerned with economic aspects of health, but the practice of 'caring'. It is this qualitative demand which has articulated the health care debate and stimulated the inclusion of 'complementary' medicine.

### Health care and political will

Meeting health care needs is a matter of social strategy and political will. Health is not an homogeneous concept, it is differentially understood. Medicine too is not an isolated discipline but an agglomeration of concepts taken from a variety of fields, only some of which belong to the natural sciences.

The social understandings of health and how to practice medicine are not fixed. Patients and primary health care professionals negotiate solutions to health care needs from an extensive cultural repertoire of possibilities. This repertoire is composed of understandings predominantly from Western medicine, but also from folk or traditional medicine and modern understandings of 'complementary' medicine.

However, there are factors common to a variety of health understandings. These include health promotion and prevention, health maintenance and treatment. Such factors are influenced by economic strategies, and cannot be divorced from considerations of community welfare. Poor housing and poverty mock any talk of initiatives based on consumer demand. There has to be a minimum level of income whereby people are fed and housed before the luxury of health choice can be exercised.

Economic factors exert a powerful influence on health care thinking by emphasizing a short term political solution of expediency before the long term outlook of necessity. Governments come and go. Chronic illness has its own insidious course.

Furthermore, it is relatively easy to assess and define the cost of speciality tests and surgical

procedures. Such an emphasis can inflate the demand for such tests whereby 'best' is seen as most expensive. This is not so easy with the 'softer' procedures of complementary medicine. For example, psychotherapy is permitted under insurance plans in the United States for the treatment of significant psychiatric disease, but not for marital stress, lifestyle counselling and situational depression<sup>13</sup>.

In Great Britain no one is barred from professional medical care by cost (although supply is limited by rationing), yet the health of the lower social classes has not significantly improved since 1947. In contrast the higher social classes utilize the National Health Service more frequently. They also turn to complementary medical practice more frequently<sup>1</sup>. Any attempts to introduce complementary health practices will have to consider how such health care is to be reimbursed if it is to be delivered to those with low incomes. Budgetary constraint in primary care may well facilitate complementary practice while retaining universal access.

It may be that some complementary medical practices, which include an emphasis on lifestyle, health promotion and health education coupled with 'low' technology, can offer low cost alternative health care<sup>14</sup>. This is not to suggest a two tier system of low cheap complementary medicine and high expensive scientific medicine, rather that a plurality of approaches may meet a wide spectrum of need. However, neither the need, nor the means available to meet it, have been clearly demonstrated.

In the light of inappropriate medical procedures in some Western countries, and marked differentials in prescribing patterns throughout Europe<sup>8</sup>, 'complementary' medical initiatives not only have an important role to play in cost reduction, but also have a place as appropriate treatment regimens. For stress related disorders complementary practices like relaxation, massage, biofeedback and psychotherapy are often not recognized as reimbursable. Yet, it is estimated in the United States that stress disorders cost the budget \$150 billion a year and result in 55 million working days being lost<sup>15</sup>.

Such mixed primary health care delivery will need to be coordinated. There is evidence throughout the world that such an integration of differing medical initiatives can be made successfully.

### Integration

Recent discussions about complementary medical practice would suggest that it is incompatible with modern scientific medicine, although some practitioners of family medicine are incorporating alternative medical practices<sup>16-18</sup>. The pragmatics of health care seem to suggest a working compatibility for the delivery of a mixed health care which is missed by theorists.

South Africa<sup>19</sup> has introduced legislation which registers practitioners of complementary medicine and requires them to be university trained. Such practitioners are independent of the General Medical Council. While this has had an influence on the number of practising complementary practitioners, it is not possible yet to say what the overall impact is on health care delivery, or to what extent orthodox medical practitioners are using complementary medical approaches.

Throughout Europe there have been varying national initiatives whereby the traditional medicine

has remained active; albeit informally, and in some cases illegally. Complementary medicine in Europe has grown from the bases of naturopathy, homeopathy and manipulative techniques. There are also national cultural differences which favour differing approaches. For example; in Finland massage is the most commonly used form of complementary practice and harks back to its roots in traditional medicine<sup>20</sup>.

For complementary medicine to flourish there has to be a climate of tolerance and active collaboration rather than restrictive licensing practices. This permissive climate leads to enhanced health care delivery. Such tolerance has been a feature of health care delivery in West Germany<sup>21</sup>.

### The Kur

The *Kur* in West Germany exemplifies characteristics of both orthodox and non-orthodox medicine (*unconventionelle Medizin*). Such health care practice is not solely explained by bio-medical criteria and is best understood as a social, historical and cultural phenomenon<sup>22,23</sup>.

The *Kur* is an institutionalized bathing activity which is also used for health promotion. Naturopathic treatments are used alongside modern bio-medical technology. *Kur* clinics are supervised by qualified orthodox medical practitioners, but also use licensed naturopathic healers (*Heilpraktiker*). The medical directors of such clinics often include some aspect of their own philosophy for therapy. Treatments may include bathing, massage, exercise and dietary considerations.

This mixed approach does not seem too far a cry from what some family practitioners in England have been advocating as avant garde practice in 'holistic' medicine.

The legislative framework for practising medical alternatives in West Germany is permissive. Patients can choose whom to consult; orthodox practitioners, complementary practitioners or naturopathic healers. This situation has developed, not without controversy and vigorous debate, in a philosophical tradition which has tried to understand the basic human condition in health and illness<sup>24</sup>. German Romantic philosophy in the 19th century attempted to criticise a natural science which was seen as fracturing nature. The maintenance of health was seen as springing from a unity of mind and body, the harmony of the individual with other human beings and a concern for the natural environment.

Again, this does not seem a far cry from our current concerns with environmental pollution, the ravages of modern living and the debate about holistic medicine.

Naturopathic medicine developed into a system of ideas which attempted to reform the dehumanization and excessive curative interventions of some medical practices. To implement these reforming ideas it was necessary to develop economic strategies for public health finance and insurance schemes. These were developed in parallel with a legislative framework which supervised the practice of naturopathic healing, inspected the premises of such healers and licensed practitioners.

It is also important to emphasize that the *Kur* tradition is a part of the tourist industry. Some of these *Kur* activities are reimbursable, either fully or in part, by the insurance companies. In West Germany free time bathing, not necessarily swimming

as a sporting activity, and sauna are leisure activities. Health care activity in this system not only belongs to the medical domain, but also belongs to a whole series of diverse activities including diet and leisure. This answers Zola's<sup>25</sup> concern about the medicalization of health care activities. In a way he falls into his own trap by assuming that medicine can take over health care understandings. Health care in practice is not seen as a separate activity from leisure and living. Given the opportunity of choice in the suitable cultural context which includes health education then health activity is inseparable from daily living.

Patients who attend a *Kur* clinic have often been treated in a hospital first. These patients fall into four main groups: patients who need rehabilitation after an accident, patients with a chronic or a serious disease condition, older patients who want to maintain their health and continue working, and those who need a rest cure after retirement. Health care in this approach is not only about promoting well-being in younger patients, which might be considered a luxury, but also keeping older patients fit enough to stay in the employment market.

West German medical care incorporates both modern scientific medicine, and the traditional nature oriented medicine. The curative role of herbal medicines, mineral waters and natural food diets, and the health promotional activities of fresh air and exercise, have remained part of recognized health care activities within the wider culture of German humanism. Complementary medicine, which includes the 'newer' therapies of yoga and acupuncture, then is part of a continuing tradition of medical pluralism, not a return to traditional methods.

If the current situations of East and West Germany are considered it is possible to see how economic and socio-political realities effect health care delivery. Both countries have the same historical heritage of 'Therapiefreiheit'; 'the freedom of a practitioner or patient on the basis of his world view - which always entails a perspective as to the meaning and causation of illness - to select for preventive or curative purposes a mode of therapy which is in conformity with this world view' (p 16)<sup>21</sup>. Modern legislation in East Germany to prevent the training of *Heilpraktiker*, an emphasis on bio-medical proof of efficacy for treatments, a centrally planned economy and limited pharmaceutical industry has meant a restriction in health care alternatives. In West Germany a liberal market economy and an acceptance that there is more than one truth in a persons's perception of his or her own health has led to a pluralist health service which can accommodate developing alternatives.

### Conclusion

A consumer based health service may well be pluralistic; ie it will offer modern scientific medicine and complementary medicine. The nature of such a complementary health care provision will vary according to local needs. Local health care initiatives in Europe depend upon three factors of availability: economic; according to third party methods of reimbursement (government or private health insurance), cultural; according to the legal, historical and philosophical traditions, and social; according to community needs.

This provision is located within a political context which sponsors initiatives by allocating the

appropriate resources. Consumer based health care is best delivered in a climate of tolerance and active collaboration between practitioners, legislators and administrators. Such a climate fosters quality of health care.

Local initiatives throughout Europe have promoted complementary practice in primary health care. The treatment of terminal illness and chronic conditions demand an understanding of the quality of the patient's life and appear to be a logical starting place. By the year 2030 the populations of Europe will have large numbers of people aged over 65 years (Britain 19%, Italy 22%, West Germany 26%, Sweden 22%, Switzerland 29%)<sup>26</sup>. The potential health care costs for these populations are massive. Active campaigns of health promotion, collaborative health care initiatives and low cost treatment approaches must be planned now while those populations are still young.

Health care, like the natural world, has an ecology. Short term changes may bring immediate political benefits but without a concern for long term changes and an overview of the whole system, then continuing damage to communities may occur.

If health care is delivered as a commodity then we fall prey to perceiving health only as a materialistic representation and only offer short-term solutions. If we consider health as a process which can be actively promoted within the span of a person's life by the allocation of appropriate resources, and that health can also be maintained by an appropriate life-style, then the expensive, but not inevitable, end process of treatment may in some cases be avoided. This entails a long-term strategy for health care. To plan a long-term coordinated strategy takes political will and can only be accomplished by active collaboration of those in health care delivery and consumption. Where treatment does occur, then consumers can be offered alternatives which fit the ecology of their own lives. Modern scientific medicine as it is delivered in primary health care will inevitably be at the core of such a pluralistic provision.

The future delivery of health care will depend upon accurate information about the management of resources. To assess health care we will need accurate and appropriate tools of assessment. In this way quality can be raised and rising costs reduced. However, quality of care is an elusive quality dependent upon the assessor. Costs, while being easier to identify may reveal not an inefficient system but one which is financially under-resourced by a political ideology which is humanly bankrupt.

## References

- 1 Yung B, Lewis P, Charny M, Farrow S. Complementary medicine: some population based data. *Complementary Med Res* 1988;3:23-8
- 2 Sermeus G. *Alternative medicine in Europe. A quantitative comparison of the use and knowledge of alternative medicine and patient profiles in nine European countries.* Belgium Consumers' Association: Brussels, 1987.
- 3 Hill R. Complementary medicine. *Advances* 1988;5:5-10
- 4 Armstrong D. Theoretical tensions in biophysical medicine. *Soc Sci Med* 1987;25:1213-18
- 5 Denner B. The uses of metaphor. *Fam Systems Med* 1988;6:364-70
- 6 Leibrich J, Hickling J, Pitt G. *Exploratory research into complementary therapies.* Wellington, New Zealand: Health Services Research Unit, Department of Health, 1987
- 7 White K. Computers, epidemiology and general practice (letter). *Lancet* 1988;i:1493
- 8 Anon. Fallible doctors. Patient's dilemma. *The Economist* 17 December 1988:21
- 9 Enthoven A, Kronick R. A consumer-choice health plan for the 1990's. *N Engl J Med* 1989;320:29-37
- 10 Coulter A, Daniels A. Computers, epidemiology, and general practice. *Lancet* 1988;iii:1493
- 11 Berwick D. Continuous improvement as an ideal in health care. *N Engl J Med* 1989;320:53-6
- 12 Crofton J. Introduction - the challenge to epidemiology and community medicine. *J R Soc Med* 1986;79(S13):1
- 13 Glenn M. The resurgence of the biomedical model in medicine. *Fam Systems Med* 1988;6:492-500
- 14 Edelmann D. Bringing mind-body medicine to the poor. *Advances* 1988;5:27-30
- 15 Moskowitz R. Establishing health insurance coverage for the treatment of stress related disorders. *Advances* 1988;5:61-4
- 16 Fulder S, Munro R. Complementary medicine in the United Kingdom. *Lancet* 1985;2:542
- 17 Wharton R, Lewith G. Complementary medicine and the general practitioner. *Br Med J* 1986;292:1498-1500
- 18 Visser J. Alternative medicine in the Netherlands. Paper presented at the EEC workshop 'The impact of non-orthodox medicine on health care expenditure', Utrecht, The Netherlands, 5-7 June 1989
- 19 Fulder S. *The handbook of complementary medicine.* London: Coronet, 1988
- 20 Vaskilampi T. Culture and folk medicine. In Vaskilampi T, McCormack C, eds. *Folk medicine and health culture: role of folk medicine in modern health care.* Kuopio, Finland: University of Kuopio, 1982:2-15
- 21 Unschuld P. The issue of structured co-existence of scientific and alternative medical systems: A comparison of East and West German legislation. *Soc Sci Med* 1980;14B:15-24
- 22 Maretzki T. The Kur in West Germany as an interface between naturopathic and allopathic ideologies. *Soc Sci Med* 1987;24:1061-8
- 23 Maretzki T, Seidler E. Biomedicine and naturopathic healing in West Germany. A historical and ethnomedical view of a stormy relationship. *Cult Med Psychiatry* 1985;9:383-422
- 24 Risse G. 'Philosophical' medicine in nineteenth-century Germany: An episode in the relations between philosophy and medicine. *J Med Philos* 1976;1:72-92
- 25 Zola I. In the name of health and illness: On some socio-political consequences of medical influence. *Soc Sci Med* 1975;9:83-7
- 26 Anon. Economic and financial indicators. *Aging. Economist* 1989;18 February:109

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## Editor's note

A recent RSM publication *Talking Health*, based on a series of Colloquia on Conventional Medicine and Complementary Therapies, will be of interest to readers, from whatever discipline, who are concerned with - and about - the provision of optimum health care.

*Talking Health*, edited by Sir James Watt and with a foreword by HRH The Prince of Wales, is available from the Publications Department, Royal Society of Medicine Services Limited, 1 Wimpole Street, London W1M 8AE, price £4.95